IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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April 22, 2008

Jill Garrett
Hands of Hope Hospice
1379 East 17th Street
Idaho Falls, Idaho 83401

RE: Hands of Hope Hospice, Provider #131547

Dear Ms. Garrett:

On April 2, 2008, a follow-up visit of your facility was conducted to verify corrections of deficiencies noted during the survey of February 19, 2008.

We were able to determine that the Condition of Participation on Interdisciplinary Group (42 CFR 418.68) is now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the deficient system to ensure compliance is achieved and maintained. Include how the monitoring will be done and at what frequency.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **May 5, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208)334-6626.

Sincerely,

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

Hands of HOPE Hospice

* Honor * Peace * Esteem

May 28, 2008

RECEIVED

MAY 30 2008

FACILITY STANDARDS

RE: Plan of Correction

Dear Ms Creswell,

Based on the survey completed April 2, 2008, this letter is to inform you of our Plan of Correction and resolution of the problems in regards to Conditions of Participation on Quality Assurance. I am providing written explanation addressing the points stated in deficiency and related to the tag definition for each deficient tag, with the new Policies and forms attached.

Tag L142:

1) All disciplines are included on the QA team and will be involved in identifying problems, deciding on monitors, evaluating data and evaluating changes. Who is involved in implementing each monitor will be addressed on the individual project outline. (See #410)
2) Gathering of data may be accomplished through surveys, patient visits, patient charts, incident reports, call logs, complaint logs, data submitted to NHPCO, and any other source available. Specific areas to be assessed and data to be collected will be decided by QA team and addressed on the individual project outline. (See #415)
3) The data will be compiled by administration for presentation to the QA team at a Quarterly QA Mtg to be analyzed, then a plan for improvement implemented. (See #415) (FYI: March June Sept Dec)
4) Patient grievances/complaints will have complaint, discussion with patient/family, and resolution documented on Complaint Documentation Form. (See # 431 for details)
5) Overall responsibility for the QA program is a function of the Governing Body, with the DON acting as the team coordinator. (See #410)
6) QA will include projects in all areas of provided services. (See #415)

Tag L143:

1) Activities used to monitor quality of care are addressed in # 410 & 415. They include Ongoing QA and Periodic QA. Details of methods for monitoring Ongoing QA are included in # 415, 420, 378/379. Details for monitoring/measuring Period QA are included in each individual QAPI Project Outline, and are specific to each individual project.
2) New QA Meeting Minutes have been created with areas to document each individual Ongoing QA and Periodic QA results and discussion to guide our meeting and show that all activities have been reported to the committee. Signatures on this form will document all disciplines involvement in the process through attendance at the meeting.
3) QA Team members and functions are identified in #410. QA Team includes all members of the Hands of Hope Hospice staff. All are involved in identifying problems, creating monitors, evaluating data and evaluating change effectiveness. Responsibilities for each project will be on the individual project outline. The Governing Body is responsible for the overall implementation and the DON is the coordinator of the team.

1379 E. 17th St. Idaho Falls, ID 83401
Ph: (208) 523-7441 Fax: (208) 542-0528

Tag L144:
Problems will be identified and resolved through the following processes and addressed and documented on the revised Quarterly Quality Improvement Meeting Minutes.

1) Problems are identified through the Quality Assessment/Self Assessment process described in #410 and 415. This includes:

Ongoing QA: Complaints
Satisfaction Surveys
Bereavement Surveys
Chart Audits

Periodic QA: Projects in each area of service which typically will continue for 1 year or until goal is met consistently for a specified time period, indicating resolution of the problem.

2) Problems are resolved through the methods outlined in #430. these include:
   a. Improvements and changes instituted in conjunction with a QA project
   b. Improvements very minor in scope that do not require a full project, only a minor change to improve care/outcomes.
   c. Education and training of employees.

Thank you for listening to my concerns about our survey and for your input to assist us in improving our services. We have restructured our Policies and Procedures dealing with QA into a more orderly format, which hopefully will assist us and you in knowing our process. I have included copies of the new Policies and the forms, etc which are referenced above. If you have any questions, please contact me.

Documentation enclosed:

1. Quality Assessment/Performance Improvement Policy # 410
2. Quality Assessment/Self Assessment Policy #415
3. Chart Audit Policy #420
4. Bereavement Policy # 378/379
5. Performance Improvement Policy #430
6. Performance Improvement—Surveys and Complaints Policy #431
7. Performance Improvement—Employee Inservices Policy #432
8. Performance Improvement—Employee Inservice Articles Policy #432.1
9. Performance Improvement—Employee Performance Policy #433
10. Quarterly Quality Improvement Meeting minutes form
11. QAPI Project Outline form
12. Current QAPI Project Outlines and monitoring forms

Sincerely,

Jill Garrett, RN
Hands of Hope Hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131547	A. BUILDING _____ B. WING _____	R-C 04/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS OF HOPE HOSPICE	1379 EAST 17TH STREET IDAHO FALLS, ID 83401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{L 000}	INITIAL COMMENTS The following deficiencies were cited during the Medicare follow up survey of your Hospice agency. The following surveyors conducted the Medicare follow up survey: Gary Guiles R.N., H.F.S. Patricia O'Hara R.N., H.F.S. Acronyms used in this report include: DON - Director of Nursing QA - Quality Assurance RN - Registered Nurse CNA - Certified Nursing Assistant	{L 000}	RECEIVED MAY 30 2008 FACILITY STANDARDS	
L 142	418.66 QUALITY ASSURANCE A hospice must conduct an ongoing, comprehensive, integrated self-assessment of the quality and appropriateness of care provided, including inpatient care, home care and care provided under arrangements. The findings are used by the hospice to correct identified problems and to revise hospice policies if necessary. This STANDARD is not met as evidenced by: Based on review of the agency's QA policies, program documentation and staff interview, it was determined the hospice failed to evaluate, study and improve the quality of care given to patients. The findings include: 1. The agency's policy #410 titled "Quality Assessment", an undated document, stated the purpose of Quality Assessment was "to provide tools by which the quality of care provided to	L 142	See attached letter	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 142	Continued From page 1 hospice patients and their families may be evaluated and any areas of concern can be improved." This included the collection of data from: a) Patient/Family Satisfaction Surveys b) Patient/Family Complaints c) Chart audits d) CNA supervisory visits. Further, the agency's policy #431 titled "Performance Improvement - Surveys and Complaints", an undated document, stated that the Quality Assurance Team would meet quarterly to evaluate "...results of Satisfaction Survey and Complaint Forms" and to: a) define any area needing improvement b) make a plan to improve in needed area c) implement change as a pilot study on a small scale d) evaluate effectiveness of the change after appropriate interval e) modify change as needed and implement hospice wide f) continue monitoring results of changes made until effectiveness is assured The plan referred to in this policy was not comprehensive because it did not specifically address how each discipline would be involved in the plan. Further, there was no provision to gather specific data to be used in the improvement of care. No definition of chart audits was included except to check which forms were in each record (i.e. a nursing assessment was in the record). No Patient/Family Complaints were received in 2007, therefore no data was collected. Patient Family Satisfaction Survey results for 2007 and 2008 were raw data which had not been compiled. The data was not compiled into a	L 142		

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L 142	Continued From page 2 usable set of quality indicators to track the quality of care. No data was collected for R.N. supervisory visits of CNA's. On 4/2/08 at 4:00 PM the agency's DON stated that the agency did not have a comprehensive QA plan. She said the agency's plan did not identify quality indicators. She said the agency did not gather specific data to be used for the improvement of care. She also confirmed that a definition of "chart audit" was not included in the plan and said data had not been gathered from chart audits for use by the QA program.	L 142		
L 143	418.66(a) QUALITY ASSURANCE Those responsible for the quality assurance program must implement and report on activities and mechanisms for monitoring the quality of patient care. This STANDARD is not met as evidenced by: Based on review of the agency's program documentation and staff interview, it was determined the hospice failed to create processes they could use to monitor the quality of care delivered to patients. Findings include: 1. Quarterly QA Meeting minutes for five quarters, four quarters in 2007 and one quarter in 2008, were reviewed. No measurable data related to the quality of care given to patients was documented as having been presented to or discussed by the QA Committee. 2. Policy #431,an undated document titled "Performance Improvement -- Surveys and Complaints" stated one of the responsibilities of the Quality Assurance Team was to "...define any area needing improvement". The policy did not	L 143	See attached letter	

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L 143	Continued From page 3 state how data would be gathered or how it would be used to monitor and improve care. 3. The Quality Assurance Team was not defined or identified. The agency's DON was interviewed on 4/2/08 at 4:00 PM. She stated no data related to the quality of care given to patients was gathered or presented to the committee. She also stated a policy defining the quality assurance team and its specific duties had not been developed.	L 143		
L 144	418.66(b) QUALITY ASSURANCE Those responsible for the quality assurance program must identify and resolve problems. This STANDARD is not met as evidenced by: Based on review of the agency's program documentation and staff interview, it was determined the hospice failed to collect data that would enable them to identify problems relating to the quality of patient care. This led to the inability by the agency to resolve potential problems relating to the quality of patient care. Findings include: 1. Quarterly QA Meeting minutes for five quarters, four quarters in 2007 and one quarter in 2008, were reviewed. There was no documentation found that showed any patient care problems were identified. Further, there was no documentation that a plan had been implemented and no data to show there was resolution of problems. QA Meeting minutes, dated 6/13/07, referred to a "change to care plan - wound tracking". There was no documentation prior to or after this entry indicating if this was a problem or how it was	L 144	See attached letter	

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L 144	Continued From page 4 monitored or resolved. QA Meeting minutes, dated 12/10/07, referred to "increased incidents of patients running out of meds". Planned change was documented as "check med supplies each visit". There was no documentation indicating the scope of the problem or whether this problem was monitored or resolved. QA Meeting minutes dated 3/5/08 referred to "IDT changes - per survey". There was no documentation indicating the problems identified on survey were discussed with the group. There was no documentation indicating what the changes were were made or how they would be monitored and resolved. 2. The agency's DON was interviewed on 4/2/08 at 4:00 PM. She stated there was no documentation showing the identification, monitoring, or resolution of problems relating to the quality of patient care provided by the hospice agency.	L 144		